

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

32082

State File No.

FILED OCT 18 1948

Registration District No.

Primary Registration District No. 1000

Registrar's No. 1083

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 yrs 4 mo 12 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Frank G. Nelson

3. (b) If veteran, name war ---- 3. (c) Social Security No. ----

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife not given 6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased not given
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 ? ? 0 hr. 0 min.

9. Birthplace ---- Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name unknown
13. Birthplace ---- Mo
(City, town, or county) (State or foreign country)

14. Maiden name unknown
15. Birthplace ---- Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Cousin Clerk(b) Address Caldwell Co.17. (a) Removal (b) Date thereof 10-14-48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Missouri, Kansas18. (a) Signature of funeral director Shuffert Funeral Home(b) Address Missouri, Kansas19. (a) 10-15-48 (b) E. B. Jenkins
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side) of Plato Hospital No 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell 13
(c) City or town Kingston Rural
(If outside city or town limits, write "RURAL")
(d) Street No. ---- (If rural, give location) 1
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13
year 1948 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Oct
1, 1948, to Oct 13, 1948;
that I last saw him alive on Oct 12, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to arterio sclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 939

Of autopsy

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury D23. Signature Forrest Thomas (M. D. SEED)Address St. Joseph Mo Date signed 10/13-48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Dixon L. Keshy

Licensed Embalmer No.....

4225

P. O. Address.....

Indy 20

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.